NOTICE OF PROPOSED CHANGES TO THE STATE MEDICAID PLAN

The State Department of Social Services (DSS) proposes to submit an amendment to the Medicaid State Plan to the Federal Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services. State Plan Amendment (SPA) 11-031 will revise hospital inpatient reimbursement methodologies and be submitted by no later than December 31, 2011.

Changes to Medicaid State Plan

The Medicaid State Plan will be amended to eliminate the October 1, 2011 and October 1, 2012 annual adjustment factors (inflation increases) of 2.2% and 2.7%, respectively, applied to the cost per inpatient discharge rate for each hospital.

Fiscal Information – Estimated Annual Change to Medicaid Expenditures

Elimination of the annual updates is anticipated to result in increased Medicaid program cost avoidance of $3.5 million in SFY 2012 and $9.6 million in SFY 2013.

Additional Information

In accordance with federal requirements governing the Medicaid program, the department will provide upon request copies of the proposed amendment to the Medicaid State Plan. In addition, copies of the proposed amendment may be obtained at each of the DSS regional offices and on the DSS web site: www.dss.state.ct.us. Go to "Publications" and then to "Updates".

Written, phone, and e-mail requests should be directed to Christopher LaVigne, Office of Certificate of Need and Rate Setting, Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033 (Phone: 860-424-5719, Fax: 860-424-4812, E-mail: Christopher.Lavigne@ct.gov). Written comments may be submitted by September 30, 2011.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

(1) The basis for payment is the Medicare retrospective reasonable cost reimbursement methodology for prospective payment system-exempt hospitals in effect prior to adoption of the Balanced Budget Act of 1997 (Medicare TEFRA Reimbursement Principles).

(a) In reimbursing for inpatient hospital services to Connecticut hospitals provided under the State Plan, the State agency will apply Medicare standards and principles for prospective payment system-exempt hospitals as specified in 42 U.S.C. § 1395ww, as amended through August 15, 1995 by various acts, including, but not limited to, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 4005 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (OBRA '90) and the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 ("OBRA '93"); and federal regulations under TEFRA, OBRA '90, and OBRA '93 in effect on August 15, 1995, including, but not limited to, 42 C.F.R. §§413.40(a)C1) et seq. and 413.86, and state regulations in effect as of August 15, 1995 (Sections 17-312-101 through 17-312-105) with: 1) graduate medical education reimbursed as a pass through based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the Medicare allowed per resident amount; 2) provider-based physician (PBP) professional costs allowed as a pass-through and computed by: a) for each ancillary cost center, the difference between a cost to charge ratio that includes PBP professional costs and a cost to charge ratio that excludes PBP professional costs is applied to Medicaid ancillary charges for that cost center, and b) for routine cost centers, the ratio of Medicaid days to total patient days is applied to the PBP professional costs in each routine cost center; and 3) organ acquisition costs reimbursed as a pass through based on the number of Medicaid transplants multiplied by the Medicare allowed amount. Effective October 1, 1998, inpatient services to patients treated in burn units certified by the American Burn Association shall be paid at a rate of $2,200.00 per day for the first sixteen days of inpatient service, not subject to cost per discharge settlement, and any inpatient days in excess of sixteen days shall be treated as a separate admission subject to cost per discharge settlement. Effective October 1, 2001 there shall be an update to a hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half percent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's allowable cost per discharge is increased to sixty-two and one-half percent of the 1999 cost per discharge, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. Effective August 1, 2003, heart and liver transplants shall be reimbursed utilizing payment rates authorized under the Medicare program. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective October 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. For the rate periods between October 1, 2002 and September 30, **2013**, there shall be no application of an annual adjustment factor to the target amount per discharge. Effective October 1, 2007, the revised target amount per discharge shall be the higher of (1) the hospital's 2007 Medicaid Cost Per Discharge Target